Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
William J. Kowalski, DC

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-14-2430-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Asked to provide both MMI and (IR)

-examination performed and report submitted within the required time

Billing & Coding done in accordance with TDI work comp guidelines

Submitted 3x. Mail & fax then remailed

Carrier did not pay"

Amount in Dispute: $550.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 1/15/14. The requestor provided designated doctor services on the date above and then billed Texas Mutual for this. Upon receipt of the bill Texas Mutual review the documentation with the bill, including the DWC-69, and declined to issue payment. The requestor appealed the denial and it too was denied.

The basis for the denial is at message modifier 225 found on the EOB. The submitted documentation – the DWC-69 form with exam date 1/8/14 while the billing lists the date as 1/15/14 – does not support the service billed."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2014	Designated Doctor Examination	$550.00	$0

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 (f) contains the required elements for billing from a healthcare provider.
3. 28 Texas Administrative Code §130.1 (d) contains requirements for reporting a Designated Doctor's

examination of Maximum Medical Improvement and Impairment Rating.

4. 28 Texas Administrative Code §127.220 (a) describes what is required in the Designated Doctor's narrative.
5. 28 Texas Administrative Code §133.210 (b) indicates that required documentation must be included with the medical bill.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT Code descriptions/instructions.

Issues

1. Does the submitted documentation support the billed services?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.10 (f)(1) found in 38 TexReg 9594 states, "The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: …(O) date(s) of service (CMS-1500, field 24A) is required."

   28 Texas Administrative Code §130.1 (d) states, "Reporting. (1) Certification of MMI, determination of permanent impairment, and assignment of an impairment rating (if permanent impairment exists) for the current compensable injury requires completion, signing, and submission of the Report of Medical Evaluation and a narrative report…(B) The Report of Medical Evaluation includes an attached narrative report. The narrative report must include the following: (i) date of the certifying examination…"

   28 Texas Administrative Code §127.220 (a) states, "Designated doctor narrative reports must be filed in the form and manner required by the division and at a minimum: … (6) state the date of the examination…"

   Review of the submitted documentation finds that the CMS-1500 presents a bill for a designated doctor's examination on date of service 1/15/14. The narrative report is for a designated doctor's examination for date of service 1/8/14. Therefore, the submitted documentation does not support the billed services.
2. 28 Texas Administrative Code §133.210 (b) states, "When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form." Because the required documentation does not support the billed services, the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 18, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.